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To cite this version:

Brenda Bogaert, Catherine Dekeuwer, Nadja Eggert, Claire Harpet, Nolwenn Bühler, et al.. Repeated hierarchies : uneven participation in research of ethical spaces in hospitals [with commentaries]. Journal of Empirical Research on Human Research Ethics, 2019, 14 (5), pp.493-495. 10.1177/1556264619831889 . hal-02059155

HAL Id: hal-02059155

https://hal.science/hal-02059155v1

Submitted on 11 Oct 2020

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Journal of Empirical Research on Human Research Ethics
1–7
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DOI: 10.1177/1556264619831889
journals.sagepub.com/home/jre
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"Repeated Hierarchies": Uneven Participation in Research of Ethical Spaces in Hospitals

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Abstract

We present a case study of uneven participation in a focus group discussion with health care professionals involved in local ethical committees. We conclude that the status of the different participants did not give adequate space for full participation of the members involved. Two commentators were invited to comment on the case study to enable further reflection on the methodology used for the target group. The first reviewer investigated whether research should address power relations and hierarchies of knowledge encountered in the study process. She also discussed whether researchers should be held ethically and politically responsible for the consequences of producing relations and hierarchies. The second reviewer looked at what focus groups say about professional practices in hospitals, what participants are willing (or unwilling) to invest, and what are the conditions for setting up ethical reflection.

Keywords

ethics, focus groups, justice/participant selection/inclusion/recruitment, communication in research, qualitative methods, research ethics

Country Context (Including Health Features)

Clinical ethical committees help clinicians deal with ethical challenges experienced in clinical practice. In France, today numerous formal and informal hospital-based committees exist with varying composition and methods; however, the "safe space" created by the ethics committee is not always safe for all participants, given the hierarchical nature of clinical work (Guerrier, 2006). Ethical committees continue to struggle with this hierarchy.

Description of the Research Situation in Which the Ethical Issue Arose

The research team (four women researchers from anthropology, philosophy, and sociology) led a focus group discussion with professionals involved in ethical reflection in hospitals. The goal of the research was to understand (a) the timing, places, and practices where an ethical reflection develops in the hospital; (b) the role of the various actors involved; (c) whether the work of the committee is led in a patient and/or provider perspective; and (d) to think critically as a group about how to make ethical committees more effective in daily practice.

The discussion was focused on two principal questions:

1. **Question 1:** In the framework of your practice, you have without doubt been confronted, either directly or indirectly, with a situation which seemed to you ethically problematic. Can one of you tell us about how this problem was questioned and eventually resolved?
2. **Question 2**: What would be the "ideal space" to discuss ethical questions in the hospital?

Two focus groups of 1.30 hr responded to the two questions moderated by a facilitator. There were 10 participants in each group, including one facilitator and one note taker. The group in question was a mix of professionals coming

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from different specialties (geriatrics, philosophy, psychology, palliative care, nursery, urgent care) as well as with different professional roles (doctor, psychologist, nurse trainer, management). They were all female with the exception of one male doctor. All had been involved in ethical committees in hospital settings, except for one student, who was a health care professional midway through her education. The student was included to provide a fresh perspective from someone not fully integrated in the daily work of clinical service. Participants were grouped via tables in a square formation, which meant that everyone could look at and speak to the group. Participants introduced themselves in a round-robin fashion via an anecdote. As Fern (2001) highlights, this differentiation stage allowed members to pick up on verbal and visual cues and to differentiate other group members in terms of status and occupation.

As we used the focus group methodology to see how questions were debated by the participants, the researcher did not directly "intervene" in the debate, except to ask follow-up questions. An important part of our thematic and conversational analysis postdiscussion was to consider the time each person put into the debate to understand at what moment they intervened and why. In the group under discussion, those in hierarchical positions initiated the discussion and largely led the debate. The student participated actively at the beginning but midway through the discussion became silent.

Case Vignette

A female doctor initiated the discussion by introducing an ethical problem experienced in her service. The student expressed her interest by asking her several follow-up questions. Midway through, a nurse started to discuss hierarchical relationships between professionals, saying that it inhibits discussion. She said this hierarchical situation needs to be addressed during the training period, before professionals go to the ward. The nurse trainer agreed with this, saying that frequently students come back from internships unhappy with the limited place for discussion on the ward and that their role as interns did not help.

In response, the student described her own experience. She said that in her service,

> When there are complicated situations, they will never ask me what I think. At school they don't teach us how to discuss an ethical problem with professionals. As a student, I have more the impression to be an observer than an "actor" because they start from the principle that we are there to learn the techniques and to apply the theory.

She gave an example in which her opinion was silenced.

> I had a situation which marked me, it was a young homeless patient . . . she gave birth while I was on my internship, and we kept this woman for 15 days because unfortunately she had antecedents of violence . . . we let the patient nurse her child, we let her create a strong relationship, and we let her hope for 15 days that she would be placed with her child. Except at the end, we learned that the courts had decided that the child would be placed in foster care and the mother in the streets. . . I wanted to say what I thought, to say what I saw during these 15 days. . . how she took very good care of her. . . to give my point of view. But they didn't give me the right to speak at all. They don't listen to us, we are just observers, and they don't give us the place to speak. . . .I am the student, I know, but from my point of view, ethically speaking, I would not have let the relationship be created, and I wouldn't have let this woman be put outside in -10 weather.

One of the respondents, a female psychologist in the same sector, responded by telling her she did not adequately understand the procedure.

> In our hospital we do a lot of evaluations, and before proceeding, we call the judge (responsible for the case), and there is a whole multidisciplinary evaluation process with different professionals. . . that allows us to do the most complete possible evaluation at that time . . .after all, it's the ethics of care. . . what we put into place for the just needs of the mother and the child. . . it doesn't mean the best, but the least worse possible solution, both for the baby and the mother.

Seeking to soothe the tension, a male doctor then intervened,

> We are used to speech which is codified, hierarchical. . . there is the space for the doctor, who has a certain knowledge, and who speaks easily. There is the speech of the nurse, who has a place too. . . but to redistribute these communication cards (learned hierarchical roles) means freeing yourself from this preprogramming, to give the speech to the student for example . . .

Despite this intervention to encourage the student's viewpoint, she did not participate in the rest of the discussion. The student came to see the facilitator postdiscussion to voice her disappointment at being placed in the same hierarchical situation as in her daily work.

Ethical Issues Arising

This situation suggests that the habitual hierarchical processes of communication among professionals were replayed in the focus group discussion. This was in line with our overall research results, which showed that relationship difficulties between committee members, the effects of hierarchy, and the lack of training in learning how to speak with other professionals block ethical reflection in these spaces.

We chose the focus group methodology to provide "a step away" from the hospital. We believed that holding the discussion in a different environment than from the clinical setting might provide a safer space for discussion. A potential strength in focus group methodology is this possibility to allow a safe space to break the silence about difficult issues, in particular when those issues are shared by others (Hollander, 2004). In addition, it was expressed by several participants during the debate that everyone, as a moral subject, has the same legitimacy to participate.

Conversational analysis of the first part of the discussion showed the student was active. The continuation of the topic into the theme of hierarchy in hospital settings and the difficulties of giving students a place gave an entry point for the student to divulge her own experience. However, the uneven hierarchical structure she experienced in the hospital was repeated during the focus group and she was silenced.

This issue was raised during the presentation of the results. The professional concerned acknowledged the tension felt during the discussion; however, she said that her response to the student was a clarification and that it was always difficult to explain procedures to students. The student did not attend the presentation, so she could not respond.

Conclusion

The status of the different participants did not give adequate space for full participation. Therefore, our methodological goal of providing a "fresh" perspective in the form of the student and a "safe space" to discuss difficult issues at least partly failed. Although this shows the constraints of a collegial reflection, it also suggests that our methodology was inadequate to provide this safe space. It also raises questions for us on how to "fairly" report on this issue as one of the persons involved did not attend the results presentation. Finally, it poses questions for the use of ethics in ethical committees in the first place. If participants are unable to take an egalitarian position even in a focus group in which there is no hierarchy or subordination, how can this function in an ethical committee in a real-world situation?

Commentary 1: Nolwenn Bühler

Should research address the power relations and hierarchies of knowledge encountered in the study process? Should it be held ethically and politically responsible for its consequences in reproducing such relations and hierarchies? Should it contribute to empower those whose voice counts so little? And if yes how to do so?

The questions raised by the case study bring into the forefront the entanglement of knowledge and power, in both health care and research. They also draw our attention to the possible tensions between the ethics of research and the ethics of health care, as well between the distinct ethical traditions in medicine and social sciences. To reflect on these tensions, I suggest starting with the latter question. Historically biomedical ethics have developed in response to scandals in healthcare or research, which have marked its history. A principle lying at the core of biomedical ethics is the widely known requirement of informed consent, which is emblematic of its concern for protecting individual autonomy. In contrast, social sciences, and especially anthropology, have responded to their own scandals by investing in the political consequences of doing research with humans (Hoeyer, Dahlager, & Lynöe, 2005). The social sciences now widely discuss the position of the researcher, asymmetrical relations with people in fieldwork, and the reproduction of power relations and hierarchies of knowledge, not only during the research process, but also later in the writing phase of research (Clifford & Marcus, 1986). In this formulation, researchers can address the moral issues rising from the research process via reflexivity and practical attempts to create more symmetrical relationships with the research interlocutors and an increased problematization of the knowledge/power nexus.

The field of gender studies has also been attentive to questions of power. The field developed a series of epistemological and methodological tools for doing socially engaged research, which mitigates against the reproduction of hierarchies of knowledge (i.e., Harding, 1987; Harding & Norberg, 2005). Although tools and reflection do exist to mitigate these complexities, enduring problems continue to occur, as described by the questions raised in this comment's introduction, as well as the case study presented. What this suggests is that these complexities are far from resolved in research practices and that they interfere unexpectedly even in a supposedly "safe space." This means that researchers are brought to address these issues both contextually and in a situated and reflexive manner. The case study reminds us, therefore, that the power relations that pervade the research process are in a way inescapable. However, this does not mean that researchers should just reproduce them without questioning. As the authors do via the questions they raise in the case study, researchers may try to address these issues using a sensitive research methodology, which aims toward an ideal of social justice, as feminist scholars invite us to do.

In the case study presented here, power relations are present at two levels, raising questions about the entanglement of ethics and politics, health care and research. First, they are present in health care organizations, which are greatly hierarchical. As studies show, through professional socialization, medical students learn to accept medicine's hierarchies and their place within it (Lempp & Seale, 2004). It is to be noted that these power dynamics are not necessarily correlated with gender (Leisy & Ahmad, 2016). Indeed, as this analysis showed, the male doctor, although taking

the lead in the discussion and in a hierarchical position in his own service, tried to support the woman student to have her voice heard after being reprimanded by another woman professional.

Situations that crystallize this hierarchy in health care organization include moments of decision making, especially when there are important ethical dimensions or a moral discomfort experienced by staff and/or patients, such as in the situation of the mother whose child is withdrawn from her custody. Some voices weigh more than others in the ethical decision-making process, according to status, experience, and the level of institutional responsibility. Is the silencing of the student's voice an ethical problem? Do the power relations shaping ethical decisions make an ethical problem? And if so, for whom?

The interaction between the doctor, who is also a supervisor and the student, indicate conflicting visions of the definition of an ethical problem. The reaction of the first one (the doctor and supervisor) conveys an understanding of ethics, which is restricted to the situation of the mother itself. In contrast, in the interaction as it is described, it is not only the withdrawal of the baby from its mother's custody, but also the exclusion of the student's vision and feelings, which affect the student's experience and perhaps the final decision about the mother and child situation. The silencing of the student's voice broadens the scope of health care ethics and points to the limits of the multidisciplinary approach advocated by the clinician. The consequences of this silencing for the ethical decision are present, but she also points to the power relations leading to such decisions as ethically problematic. The exclusion of the younger medical professional's view, which in this situation encompasses those that are subordinate and are considered as having an inferior status, which Spivak (1993) calls *subalterns*, seems to stand out as the most important ethical problem for this young professional. This conveys a broader understanding of ethics as inextricably linked to politics. Power relations are not only present in the situation of the mother itself, as the doctor and the other professionals were probably all attuned to, but they are also present and shape the very process of making the ethical decision.

This brings us to the question of how to promote a broader understanding of ethics than the one conveyed by biomedical ethics. Instead of a definition of ethics focusing on the individual only and relying on abstract principles to support decisions, the dialogue created by the authors through their research could bring them to work toward a broader definition of ethics, enriched by social sciences insights. The case study presented could in this sense be heuristically and practically used to engage a reflexive discussion with health care professionals about ethics as a situated and relational practice, which is shaped by power relations. The role of the ethical committees as sites where the hierarchical relations shaping the organization of health care are reproduced could be brought out as an ethical problem in itself. However, bringing politics to ethics, especially in a space dominated by those whose social status and symbolic resources might generate resistances, could also be counterproductive. A challenge, for the authors, and researchers working in health care more generally, comes to the forefront: How can we discuss the ways power relations affect ethical decisions in health care? Bringing the different members of the medical team together, independent of their status, into a reflexive discussion with the goal of discovering not only their different understandings of ethics but also their underlying assumptions, might be a possible idea for action. An additional idea would be to focus the discussion on the entanglement of ethics and politics, for example, by addressing the question of social justice and the inclusion/exclusion processes at work in ethical decision making in health care.

A second level where power relations are present is at the level of the author's research itself. Drawing on anthropology and gender studies' reflexive turn, we could suggest that power shapes any research process, and that a way of addressing this in research is to recognize our own situation in the multiple social hierarchies shaped and "to write ourselves in the analysis" (Presser, 2005). Moreover, as the case study shows in an exemplary manner, the research situation and the way it reproduces the hierarchical relations in health care and ethical committees is in itself a powerful tool to understand ethics not as an abstract principle, but as it is enacted and experienced in practice. In other words, it provides a lens through which to understand the entanglement of power, knowledge, and ethics, which might turn out to be the most relevant insight of the research process. This means that instead of trying to remedy the situation described by appealing to the methodological principles of classical epistemological standards, I would suggest opening the research process to the tools of feminist methodology, such as standpoint epistemology and sensitive methods (Carroll, 2013) to integrate conceptual and epistemological thinking on the reproduction of hierarchies in research. This might enrich the classical methods of focus groups and allow the authors to go back to their research questions from another perspective, a viewpoint, which would equip them to better address how exclusion and inclusion processes are at work in the ethics of healthcare. It would perhaps also nourish their reflections about how to create a "safe space" for research participants in relation to power relations. Finally, it could contribute to bring the authors to think reflexively about the motives beyond their research and the nature of their engagement. Their case study brings us to think about the possibility, desirability, and means of developing research, which is socially engaged and works toward social justice as an ethical, political, and epistemological issue.

Commentary 2: Julie Henry

What Focus Groups Say About Professional Practices in Hospitals

The experiment proposed in April 2017 by the authors of this article was ultimately a sort of *mise en abyme*, voluntary or otherwise. By inviting participants to talk to each other about ethical practices in hospitals, they in fact situated them so as to stage a form of ethical discussion! Herein lies one of the great interests of this experiment: The lessons learned in the practice of ethical discussion in hospitals can be drawn as much from the behaviors of participants with respect to each other in the focus group (observations of exchanges) as from discourses presented by each of them in response to the questions asked (verbatim answers).

In this context, how can we fathom a health care student being rebuffed by a seasoned professional when mentioning a clinical situation that had caused her difficulty? How do we interpret this, given that the participants of this focus group were selected for their experience and specific engagement with ethical approaches in hospitals? Let us, in Spinozist terms, bet that it is neither a matter of ill will (not wanting to enter into an ethical discussion) nor a deliberate intention to discredit the participant's discourse (consciously considering herself more legitimate than other members to participate in the focus group discussion).

What this spontaneous reaction shows (reprimanding a student about something she perceived as problematic in a hospital situation) is that an individual does not become somebody else simply because that individual enters into an ethical discussion. Just as individuals remain human (with their passions, emotions, and interests) when they enter society or when they assume a position of authority in an institution or country, as Spinoza would say, likewise they remain members of their profession when they participate in a focus group on ethical spaces in hospitals. And in the context of caregiving professions, becoming a member of the profession initially amounts to following the hierarchies in place at hospitals. Therefore, entering into dialogue in a different way is not a matter of goodwill; it implies having had the opportunity to think about the postural habits of one's profession in advance. As Irving Goffman (1982) shows, a person in the context of a social activity must not be seen as a person in and of himself, but rather in terms of his special capacity or status in that situation. Rules of conduct make it possible for the person to act and be a particular kind of person, notably in this situation a health care professional with a certain level of expertise. According to Goffman, when these rules of conduct are broken, both individuals involved risk becoming discredited.

This reaction (dismissing the student for her ignorance of the procedure applied in this situation) also testifies to a place of friction between an ethical discussion that is sincerely open and reflexive and professional habits constituting a foundation that cannot be questioned with impunity. There seems to be a sort of distinction between what can be discussed (a lack of resources, the sometimes excessive demands of patients, what being confronted with death can bring out in caregivers, etc.) and what cannot be (here, the result of an established procedure). It is as if the existence of a procedure in this precise context shuts down ethical reflection, as if the fact of knowing and having respected a procedure had singlehandedly rendered any ethical discomfort or questioning impossible. By seeking to avoid judgment of the individual who made these remarks but to understand what they are the symptom of, we can see to what point we are dependent on representations that have been instilled in us in our professional environments, and to what point confusions regarding legislation, regulatory frameworks, protocols, quality control and ethical reflection can be detrimental to the individual. We can, therefore, find similar obstacles in legislation: for instance, euthanasia is certainly illegal in France and does not constitute a legitimate response to a request, but to affirm this and hide behind the law must not be the only answer given to a patient requesting it as part of ethical caregiving practice.

What Participants Are Willing (or Unwilling) to Invest

If we now question the context that was proposed to participants in the focus group and the way in which they have—or have not—engaged with it, we can also draw conclusions from the situation where a student, after having been reprimanded by a professional, decided to keep quiet and no longer participate in the discussion. If we shift the focus from the professional (in what her attitude says of professional habits and representations of ethics in hospitals) to the student, we can see that it is not so easy, even if we are allowed or even encouraged to take the floor in these discussions and to assert ourselves to whomever it may concern. Indeed, despite the intervention of another participant legitimizing her inquiry, the student in question did not rejoin the discussion. She only expressed her disappointment to the moderator once the focus group discussion concluded, when the moderator could make a note of it for the remainder (and analysis) of the research but at which point she was no longer able to intervene to remedy it.

It is not uncommon to see caregivers withdrawing in silence at the first difficulty encountered in making their voices heard, or complaining to those who have no ability to act and avoiding speaking to the individuals involved. What this teaches us, beyond the specific situation of this student in the focus group, is that it is not easy to position ourselves, to persist in making our voices heard, and to take

responsibility in backing our own discourse when it does not seem to warrant support in the first place. Even if the conditions are externally imposed, taking part in an ethical discussion also requires a commitment on behalf of the individuals concerned.

The question of commitment is also relevant to this case study. Although the student expressed her disappointment from the position she was not able to take in the focus group, she was not present to talk about it in a more supportive way during the presentation of the results. The seasoned professional was present to make her point of view known during the focus group and during the results presentation and was, therefore, able to justify her response. These are elements that need to be questioned in our work on ethical spaces in hospitals. This is certainly research that interests us from a philosophical point of view, but what are we to do when practitioners do not feel concerned by the results of this research, which nevertheless focus first and foremost on their own practices? At least, not sufficiently concerned to make themselves available when the results are released and when we make ourselves available as researchers to conduct this research with them.

It does not seem to me that it is simply a question of time: The health care providers themselves would concede that they spend a lot of time in meetings that offer them very little in terms of their practice, whereas these ethical questions directly concern them. I think there are two aspects to consider regarding this matter. First of all, this says something about the status given to ethical reflection, or more generally research in the human and social sciences in hospitals. Everyone is prepared to recognize its importance and relevance . . . but once everything else has been done, it can be done in the remaining available time, if we really have nothing else to do and we still have the energy for it. On the contrary, it also says something about the difficulty that practitioners may have in entering into reflections that challenge them and question them as individuals, and beyond the professional posture behind which they can hide in situations, which are too inquisitive and that may be critical of these postures.

What Are the Conditions for Setting Up Ethical Reflection?

An open question remains: what do we do about the results of research that could be perceived by a participant as questioning her or his attitude—whether it is the professional who reprimanded the student or the student who did not rejoin the discussion? How can we at once produce and develop the results of research but not put those individuals having accepted to participate in the research in a difficult situation? How do we maintain a constructive, trusting relationship with them? In this case, we could imagine—which in no way presupposes it to be the case—that the student, disappointed by the way the focus group played out, did not wish to continue the experiment by coming to discuss it during the presentation of results. Or perhaps the seasoned professional considered that she had fulfilled her responsibility in the focus group and that her role ended there. Should this professional be encouraged to participate in other presentations and discussions of results, even at the risk of perceiving the results as too critical of her as an individual? Will this in turn put her, as well as the researcher, in a difficult situation?

What first needs to happen is to depersonalize the research results. This does not simply involve anonymizing them, because the individuals concerned can easily identify themselves and this will not ease their difficulty in having their attitude and practices questioned. Indeed, when the case concerns a particular service, other individuals in that service will also be able to identify them. More profoundly, this involves demonstrating that what interests us is not so much commenting on the attitude and/or remarks of any particular individual, but understanding what they represent and what they allow us to interpret about ethical places. Namely, what does this tell us about the conditions of setting up ethical discussion? What do we need to set up to bring about a major change in how ethical discussions take place? In this way, the absence of the principal protagonists is not actually an obstacle, because it is neither their confrontation nor their justifications that are sought.

One way to address the results of this research without harming participants, but by ensuring that they can still benefit from it, would be to expose the implicit aspects of their postures to assist them in future evolutions. Based on the principle that the participants were all of goodwill (respecting the remarks of others, engaging in discussion, considering everyone's perspective as legitimate, using the means at their disposal to take full advantage of the designated space, etc.), we can see that being placed under externally imposed conditions, which make this discussion possible (a dedicated time, a different place, the presence of moderators), is not sufficient. This is because precisely putting aside our professional habits is not realistic, because we are not even aware they exist. One way to present the results of the research would, therefore, be to highlight what has emerged for the researchers: The need to lead participants to reflect on their reciprocal postures, to do so over a long period of time and in direct connection with their way of being professionals. This can be done by emphasizing that this is a result for the researchers themselves, who had not anticipated this need and who overly insisted on the "place" of ethics. Emphasizing this is not inherently serious: it is a natural, anthropological trait, and we can allow ourselves the time to do it, because we all have our professional and personal lives ahead of us to enter into ethical discussions, to learn about ourselves and our postures, to repeatedly and

indefinitely participate in other research that pushes us to reflect on our practices (research practices included).

Authors' Note

Julie Henry is also affiliated as an assistant professor with Ecole Normale Supérieur de Lyon.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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